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ABSTRACT

The research literature on the impact of counselor smoking has yielded unexpected results, indicating no difference in perceptions of smoking or nonsmoking counselors, or more favorable reactions to smoking counselors. To further study clients' perceptions of therapists' smoking, a study was designed which evaluated the impact of a female therapist who smoked, simply gestured, or did neither; and the counselor's feminist versus traditional values across smoking conditions. Female undergraduates (N=148) completed a demographic questionnaire, the Attitudes Toward Women Scale, the Counselor Rating Form-Short, the Counselor Evaluation Rating Scale, and the Counseling Expectancies scale. Subjects were also provided one of four therapist information descriptions (T=traditional, F=feminist, ET=explicit traditional, EF=explicit feminist) and viewed a videotaped counselor in one of the smoking conditions. Smoking female subjects were replaced with non-smokers. The results showed that the smoking female counselor affected only subjects' perception of therapist trustworthiness. There were no differences between the ET and EF condition in subjects' perceptions of the counselor's ability to help or between the T and F condition; however, both EF and ET counselors were perceived as more capable of helping. The findings suggest that counselor smoking does not negatively affect the therapy process. (MCF)

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Impact of Therapist's Feminist Values and Smoking on Prospective Clients

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Impact of Therapist's Feminist Values and Smoking on Potential Clients

In recent times efforts have increased to dissuade, prevent, and/or stop smoking. The health hazards of smoking have received national attention with the Surgeon General's reports on smoking and health (U.S. Public Health Service, 1964; 1975; 1980;) A further development in this area has been the growing concern over the hazards of smoking to nonsmokers exposed "second hand smoke" (Beware Smoky Rooms, 1980).

Nonsmokers have become increasingly active and successful in curtailing situations in which they could come into contact with exhaled smoke from smokers. Though claims are made that exposure to second hand smoke poses a health risk, debate continues as to whether and in what ways nonsmokers' exposure to secondary smoke constitutes a meaningful health peril for adults (e.g., Foliart, Benowitz, & Becker, 1983; Garfinkel, 1981; Hines & First, 1975; Huber, 1975; Jarvis, Tunstall-Pedoe, Feyerabend, Vesey, & Salloojee, 1984). However, if exposed to secondary smoke, young children may be at some heath risk (Huber, 1975).

Consideration of physical health risks aside, questions remain about the psychological reactions to smoking. The literature as a rule suggests that smokers would be at a disadvantage in interpersonal situations. Individuals, especially non-smokers, perceive cigarette smokers as less considerate of others (Bleda & Sandman, 1977), less physically attractive (e.g., Polivy, Hackett, & Bycio, 1979), and more undesirable in terms of interpersonal interaction and personality

characteristics (Campbell, 1981; Clark, 1978a, 1978b; Dermer & Jackson, 1984). Studies of in vivo cigarette smokers have shown that smokers elicit shorter latencies to flight reactions (Bleda & Bleda, 1978) as well as a desire for more personal territory (Kunzendorf & Denny, 1982).

Findings of the survey by the National Clearinghouse for Smoking and Health (U.S. Public Health Service, 1975b) confirm non-smokers' general negative view of smokers. Furthermore, in that survey 88% of the non-smokers and 63% of the smokers agreed that people in health professions should set a good example by not smoking.

Such findings would lead one to think that therapist smoking would be one behavior that could differentially effect a therapist's ability to influence clients. Strong (1968, 1978) pays particular attention to the role of interpersonal behaviors and factors that facilitate or hinder the ability of one person (therapist) to influence another person (client).

A variety of variables (e.g., therapist reputation, professional title, race, sex, attire, office decor) have been related to clients' initial impressions of therapists and to clients' expectancies for therapeutic help. (See reviews by Corrigan, Dell, Lewis, & Schmidt, 1980; Heppner & Dixon, 1981; Strong, 1978.) Interestingly though, the little research literature on the impact of counselor smoking has yielded some unexpected findings.

Poussaint, Bergman, and Lichtenstein (1966) investigated the effects of treating physician's smoking or not smoking in front

of patients during treatment to help patients stop smoking. Smoking on the part of the treating physician was unrelated to outcome during the treatment period, drop-out rates, or outcome at follow-up six months after treatment. It should be noted that only during the initial interview did the physician smoke and that the initial interview was the only extensive interview analogous to a therapy session. Lichtenstin, Ransom, and Brown (1981) reported that the credibility of the rationale for treatment programs to stop smoking and the personal attributes of the programs' counselors were enhanced if the counselors were ex-smokers. No differences emerged between current and never-smoking counselors. The work of Lichtenstein and his colleagues suggests that in some specific counseling situations (i.e., programs to stop smoking) whether the counselor smokes or not has little bearing on the treatment, clients' perceptions of the counselor, or credibility of the treatment program. Possibly, as Lichtenstein et al. (1981) suggested, these differences simply represent an affirmation of the clinical lore that addicted clients prefer ex-addicts or fellow addicts as counselors because of their shared experiences and consequent ability to emphathize.

Schneider (1984b) measured women observers' impressions of a video taped male counselor who smoked (cigarette or pipe) or did not smoke while interviewing a female client. Observers failed to differentially discriminate between the smoking counselor's or the control counselor's (non-smoking) degree of expertness, attractiveness, or trustworthiness. Subjects gave the non-smoking counselor more favorable ratings in terms of his

knowledge of psychology, ability to help, and someone the subject would be willing to consult. However, in judging the counselor's helpfulness in dealing with 18 specific problems, the females only rated the counselor differentially on three problems (study problems, academic performance, drugs). For these problems subjects had less confidence in the pipe smoking counselor's ability to help. Ratings of the non-smoking and cigarette smoking counselor did not differ for any of the 18 problems.

Stewart-Bussey (1983) assessed smoking and non-smoking prospective female client's impressions of smoking versus non-smoking counselors. No differences emerged in the women's perceptions of the counselors' attractiveness, expertness, or trustworthiness. However, complex interactions occurred for impressions of the counselors' level of regard, congruence, and ability to help with some specific problems. These interactions indicated that smoking counselors were sometimes perceived more favorably than when not smoking.

Modifications in the present investigation were incorporated to study further potential clients' perceptions of therapist's smoking. First to control the arm movements involved in smoking, Schneider (1984b) had the counselor in the non-smoking control condition use an equal number of gestures. To evaluate the impact of smoking versus simple arm gestures, the present study included a condition in which the counselor made no gestures. Second, in contrast to previous investigations (Schneider 1984b; Stewart-Bussey, 1983) the present study used a female rather than a male counselor. The impact of smoking female therapists was of

interest because of the high prevalence of smoking among women in two occupations related to mental health services: psychologists and psychiatric nurses (U.S. Department of Health, Education, and Welfare, U.S. Public Health Service, 1980). Third, it is generally accepted that the prevalence of cigarette smoking in women has increased over the past 50 years (U.S. Public Health Service, 1979).

Commercial advertizing has associated cigarette smoking in females with enhancement of women's status in a social, political, and economic world which is portrayed as masculine dominated. To investigate the possibility that a female counselor's status might be enhanced by such an association and by espousal of feminist values, the counselor's feminist versus traditional values were systematically manipulated across counselor smoking conditions. Evidence suggests that prospective clients respond differentially to a therapist's espousal of feminist values. Schneider (1984a) found potential female clients perceived a "feminist" therapist as somewhat less trustworthy than a traditional therapist. However both Lewis, Davis, Lesmeister (1983) and Schneider (1984a) reported that therapists with "explicit feminist" values (vs. therapists with traditional values) evoked greater confidence in being helpful with career issues. For more personal, intimate problems therapists with more "traditional" therapy orientations elicited more confidence in potential clients.

Method

Subjects

The final sample of 148 undergraduate women volunteers had a mean age of 21.2 years (SD = 5.8). All subjects earned research credit for their participation.

Measures

Demographic questionnaire (DQ). The demographic questionnaire gathered descriptive information concerning subjects' (e.g., age, mariatal status).

Attitudes Toward Women (ATW). Spence, Helmreich, and Stapp's (1973) shortened version of the ATW scale was used to assess degree of feminist orientation. ATW scores range from 0 to 75 with high scores indicating a more contemparary, profeminist attitude. Correlations between the short and long forms of the ATW range from .95 to .96

Counselor Rating Form - Short (CRF-S). Barak and LaCrosse (1975) developed the Counselor Rating Form to assess the dimensions of counselor's attractiveness, expertness, and trustworthiness. The CRF-S (Corrigan, Dell, Lewis, & Schmidt, 1983) abridged the Counselor Rating Form to four items to assess each of the three counselor dimensions . Scores range from 4 to 28 for each of the three scales with higher scores representing greater degrees of attractiveness, expertness, and trustworthiness. Reliabilities for the CRF-S range from .82 to

Counselor Evaluation Rating Scale (CERS). The CERS is a semantic differential instrument tapping several concepts related to counselor credibility along the evaluative dimension of meaning (Atkinson & Carskaddon, 1975). Ratings on three 7-point

scales (i.e., good-bad, valuable-worthless, meaningful-meaningless) are summed to obtain an independent score for each of five concepts: counselor's knowledge of psychology, counselor's ability to help the client, counselor's willingness to help the client, counselor's comprehension of the client's problem, and the counselor on the tape as someone I would go to see if I had a problem to discuss. For each concept, scores have a possible range from three to 21 with low scores indicating a more positive evaluation.

Counseling Expectancies (CE). The CE consists of a list of 18 specific personal problems adapted from Lewis et al. (1983). On 6-point Likert scales, subjects indicate their degree of confidence that the counselor would be helpful with each problem, where 1 = no confidence and 6 = extreme confidence. Two problems were added to Lewis et al.'s list: "losing grip" on reality and religious conflicts.

Post-experimental Assessment. This questionnaire was completed after the experiment and was used to assess other subject descriptive characteristics. It was at this point subjects' smoking status was determined.

Stimulus Tapes

A script of a brief initial interview adapted from Cash and Salzbach (1978) was enacted by a female doctoral candidate in counseling psychology who served as the interviewer and a female doctoral counseling psychology student who role-played the client. Modifications consisted of omitting two personal and two demographic disclosures from Cash and Salzbach's script. In

the revised script the client describes symptoms of anxiety, low self-esteem, sleep difficulties, and a submissive-deferential attitude.

Three vignettes, each using the same script, were videotaped. In the first taping, the counselor lit a cigarette and took six additional puffs during the conversation. At identical points in the dialog in the second vignette, the counselor made an arm gesture by stroking her cheek, upper lip, or brushed back her hair. Finally to investigate the impact of arm movements, in the third taping the counselor neither smoked nor gestured. After rehearsing the parts, all three vignettes were taped in a TV studio against the same background. This procedure allowed for technical control over the counselor's attire, visual background, camera angle, and lighting. Cue cards were used to equate timing of intervals in the dialog between either counselor inhalations or arm gestures. On the final vignettes, the confederate client sat offscreen and the counselor was visible only from the waist up.

To check for audio differences between the vignettes, each of three groups of female undergraduates (total N=46; M age=21.4 years) rated the audio portions from the vignettes. These subjects were instructed that they would hear a brief intake interview between a counselor and a student and then would be asked to report their impressions. Using 8-point scales, subjects rated: (a) the likelihood they would continue conseling with the therapist, (b) their optimism about the helpfulness of the counselor, and (c) how physically attractive they thought the

therapist was. Separate one-way analysis of variance (ANOVA) for each of these ratings revealed no differences between the three audio tracks.

Pre-Therapy Information .

Four announcements of services were prepared which conveyed differing amounts of information about a female therapist. The traditional (T), feminist (F), and explicit feminist (E-F) announcements replicated those used by Lewis et al. (1983). In the T condition, subjects read a yellow-page announcement which was a listing for a woman, licensed clinical psychologist who provided individual and marital counseling. Participants given the F announcement received an identical listing with the words "feminist therapist" added. Subjects in the E-F condition received a summary page containing the same information in the F announcement with the addition of a brief statement concerning the values and assumptions the therapist espoused. Finally, the explicit traditional (E-T) announcement contained the same information found in the T listing along with a brief statement of the therapist's values and assumptions. The E-T summary sheet was composed to mirror the information on the E-F sheet as closely as possible. To accomplish this goal, all gender references were changed to non-sexist pronouns and two brief statements about the social, economic, and political status and goals of women were replaced by descriptions of experiential and relationship issues in counseling (Schneider, 1984a).

Procedure

A female experimenter greeted arriving subjects in small

groups (2 to 3) who then completed the DQ and AWS. Subjects were provided one of four (T, F, E-T, E-F) therapist information descriptions and viewed one of the three videotapes. Each of the four descriptions was completely crossed over the three videotapes resulting in 12 cells. To avoid confounding the subjects' smoking status, smoking females were replaced until cell frequencies of 12 to 13 non-smoking subjects were obtained. Thus 34 (19%) of the 182 females tested were not included in the final sample.

Results

To determine whether subjects' were equivalent in terms of their feminist orientations, a 3 x 4 (smoking conditions x announcements) analysis of variance (ANOVA) was performed on the ATW scores. Neither main effects nor the interaction were significant. The overall mean for the sample was 53.44 (*SD* = 5.83).

Separate 3 x 4 multiple analysis of variance (MANOVA) was performed for each conceptually related set of dependent variables. All MANOVAs used Wilks lambda criterion. Since all subjects did not complete every item, some MANOVA's involved slightly different *n*'s.

The first MANOVA included the CRF-S attractiveness, expertness, and trustworthiness scales. Table 1 shows a significant effect occurred for smoking conditions only. Table 2 presents the means and standard deviations for the CRF-S.

Insert Table 1 and 2 about here

The only univariate effect occurred for trustworthiness. Using Duncan's range test to examine the smoking conditions, participants viewed the cigarette smoking counselor as less trustworthy then when the counselor did not smoke but gestured ($p < .005$) or when the therapist neither smoked nor gestured ($p < .01$).

MANOVA of the CERS dimensions summarized in Table 1 show that subjects discriminated only among therapist announcements. Table 3 presents summary data for the CERS for

Insert Table 3 about here

the announcements. Generally therapists with longer, more specific announcements received more favorable evaluations on all the dimensions. Univariate F's for all CERS dimensions, except counselor's willingness to help, were significant. Using the Duncan range test to examine the univariate differences, the T and F announcements portrayed the therapist as less knowledgeable about psychology than the E-F information ($p < .005$) and as less knowledgeable then the E-T therapist ($p < .01$). No differences occurred between the E and T counselors or between the E-F and E-T therapists.

For subjects' perceptions on the CERS dimension of the counselors ability to help, no differences emerged between E-F and E-T or between the T and F announcements. However, both the E-F and E-T counselors were perceived as more capable of helping than both the T and F service providers ($p < .001$). The pattern of differences on the CERS concept of counselor's comprehension of

the client's problem duplicated the findings for ability to help.

On the last CERS concept, subjects' willingness to consult the counselor, both the E-F and E-T did not differ from each other but did differ from F ($p < .005$) and from the T therapists ($p < .05$). The latter two therapists did not differ between themselves.

Table 1 also summarizes the MANOVA for the females' CES about receiving help from the counselor for 20 specific problems. No main effects or interaction were observed.

Discussion

Smoking on the part of a female counselor selectively affected only subjects' perception of therapist trustworthiness. The fact that the counselor in the cigarette smoking condition was perceived as less trustworthy than in both the gesturing and non-gesturing vignettes implicates smoking per se as the critical factor. Neither Schneider (1984b) nor (Stewart-Bussey, 1983) found differences in females' perceptions of the expertness, attractiveness, or trustworthiness of smoking and non-smoking service providers. Further research is needed to confirm whether the present findings are idiosynciatic to same sex counseling dyads and to determine the impact female counselor smoking has on male clients. Popular media often associate achievement of greater political, economic, and social status in women with their smoking. Presumably in the counseling setting the therapist has a status advantage over the client. The interactional configuration of greater status and smoking may put a female therapist at greater disadvantage vis-a-vis male

clients. Although Stewart-Bussey (1983) found no differences between smoking and non-smoking subjects' perceptions of therapist's smoking, research needs to verify whether her findings are generalizable to male subjects.

With respect to the length and specificity of therapist announcements, therapists with more detailed announcements were evaluated more favorably on the CERS but no differently with respect to CEs. The finding of no differences in subjects' expectations for obtaining help on the 20 specific problems is interesting in light of the results reported by Schneider (1984a) and Lewis et al. (1983). However, important methodological differences exist between these latter two investigations and the current study.

The CERS differences suggest women may be more concerned about meaningful dimensions relevant to undertaking therapeutic work (e.g, counselor's knowledge, ability, and comprehension) than about therapist's personal smoking habits or personality characteristics. Thus females may be less comfortable when they have less knowledge about therapists' values as the shorter E an T announcements depicted. In part Schneider's (1984a) results seem to go along with this. He found that females perceived the therapist depicted in the brief F announcement less trustworthy than in the T, E-T, or E-F conditions. However, he observed no differences in males' perceptions.

Considered together with other findings (Lichtenstein et al., 1981; Poussaint et al., 1966; Schneider, 1984b; Stewart-Bussey, 1983), the results seem to suggest that the evidence does

not warrant an assertion that counselor smoking during interviews overwhelmingly mitigates against the therapy process. This is not to say that smoking has no physiological effects, only that the psychological effects may be another matter.

Additionally with the exception of Poussaint et al. (1966), the above evidence is of an analog nature. Evidence of the psychological consequences of counselor smoking during therapy from in vivo settings might be helpful in clarifying the picture.

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Table 1

MANOVA Results for Dependent Variables

Scales	Smoking Conditions by Announcements F	Smoking Conditions F	Announcements F
CRF-S	.72	2.79**	1.66
CERS	.95	1.57	2.51*
CE	.98	.98	1.24

Note. CRF-S = Counselor Rating Form - Short; CERS = Counselor Evaluation Rating Scale; CE = Counseling Expectancies.

*p <.05

**p <.005

***p <.001

Table 2

Means and Standard Deviations for CRF-S by Smoking Conditions

CRF-S	Smoking Condition			F
	Cigarette[a]	No Cigarette, gesture[a]	No Cigarette, no gesture[b]	
Expertness				
M	12.7	15.7	15.0	2.75
SD	6.15	6.54	5.79	
Attractiveness				
M	14.1	15.1	16.2	1.12
SD	6.22	6.35	6.07	
Trustworthiness				
M	15.6	19.4	18.8	5.51*
SD	6.55	5.30	4.86	

Note. Higher scores indicate perception of greater degrees of attributes.

[a] $n = 47$; [b] $n = 46$.

*$p < .005$

Table 3

Means and Standard Deviations for CERS Dimensions by Announcements

CERS Dimension		Announcement				F
		T[a]	F[b]	E-F[b]	E-T[b]	
Knowledge of psychology	M	12.4	12.8	10.3	10.5	3.78*
	SD	4.42	4.02	4.7	4.32	
Ability to help	M	13.8	13.3	10.5	10.1	6.63***
	SD	4.76	4.28	5.02	4.12	
Willingness to help	M	11.0	11.3	9.0	8.9	1.94
	SD	5.57	4.83	5.33	5.27	
Problem comprehension	M	11.6	11.1	8.4	7.0	7.50***
	SD	4.84	4.84	4.69	3.94	
Someone I would consult	M	16.2	17.1	13.5	13.9	4.71**
	SD	5.19	4.11	5.39	4.93	

Note. T = traditional, F = feminist, E-F = explicit-feminist, E-T = explicit-traditional. Lower scores reflect more positive evaluations.

[a] $n = 35$; [b] $n = 36$

*$p < .05$

**$p < .01$

***$p < .001$